GREAT PLAINS REGIONAL MEDICAL COMMAND
Warfighter Refractive Eye Surgery Program

Instructions for Completing the Enclosed Forms

1. Please complete all the information in the forms and ensure that it is LEGIBLE, so please print.

2. Since we will use email as the first line of communication please make sure that the email address you provide is one that you regularly use.

3. If at any time you change your contact information please be sure to let us know the new information.

4. YOU MUST INCLUDE A COPY OF YOUR EYE PRESCRIPTION THAT IS *OLDER* THAN ONE YEAR to have a completed packet to be reviewed and approved.

5. Instructions for each form enclosed below are as follows:

    - ***PRK Application Form:*** be completely filled out and signed by you.
    - ***Commander's Authorization Letter:*** Turn in to be signed by your commander. If your commander is not available and someone signs in their place, assumption of command orders must accompany your authorization.
    - ***Patient History Questionnaire:*** To be completely filled out and signed by you down to the technician comments.
    - ***Managed Care Agreement:*** Needs to be filled out and signed by you. Take this with you to your pre-operative evaluation to be signed by the doctor who will be responsible for your surgery follow-up care.

6. A complete packet includes the following:
    1. Completed *PRK/LASIK Application* Form
    2. Signed *Commander's Authorization* Letter
    3. Completed *Patient History Questionnaire* Form
    4. Signed *Managed Care Agreement*
    5. Eye prescription Older than one year
    6. Pre-operative evaluation
    7. Color copy of all eye scans (Topography and/or Orbscan)

    ***ALL SCANS MUST BE SUBMITTED IN COLOR

    If you have access to a color scanner please e-mail them to margaret.ross@amedd.army.mil as an attachment or if you do not have access to a color scanner, please mail them to the address below with a tracking number.

7. Submit the complete packet to "GPRMC Refractive Surgery Coordinator" in the following ways:
    1. Fax #: 210-295-2749
    2. Mail to:

    2410 Stanley Road Bldg 1029 Suite 121
    Fort Sam Houston, TX 78234-6230.

GPRMC PRK/ LASIK Application Form
Warfighter Refractive Eye Surgery Program (WRESP)

(Read Instructions completely before filling out application)

INSTRUCTIONS:

1. Type or print legibly all information on this form.

2. Enter all dates in the format dd-mmm-yyyy (example: 05-Aug-2006).

3. Applicant must* DISCONTINUE CONTACT LENS WEAR IMMEDIATELY *after submitting application. Patients must be out of soft contact a* minimum 30 days *prior to initial screening. Patient's will not be referred to a laser center until corneal stability is demonstrated.

4. FIRST Contact your Unit Surgeon to determine if you need to complete any additional waiver's or authorizations before receiving surgery especially if you are in aviation, or special duty status.

5. Submit this completed form and your signed Commander's Authorization to your local Medical Treatment Facility eye clinic to be scheduled for a screening appointment.

6. Incomplete forms will not be accepted and will be returned. Please allow three weeks for processing.

7. You will be notified of your status by email so please make sure that the email address you provide is one that you regularly use.

GPRMC Warfighter Laser Centers	***Location***
Wilford Hall Medical Center	Lackland AFB, San Antonio, TX
Carl R. Darnall Army Medical Center	Fort Hood, Killeen, TX
US Air Force Academy	Colorado Springs, CO

Last Name:	First Name:	MI:	Rank/Grade:	Date of Application:

SSN: no dashes	Date of Birth: dd/mmm/yyyy	Age:	Sex: ☐Male ☐Female	MOS:	ETS Date: dd/mmm/yyyy	Likely to Deploy, PCS or attend School in the next 12 months? Approximate Date: (if known)	☐Deploy ☐PCS ☐School

Unit:

AKO/Primary email address: (must be one you check regularly)

Duty Address:

Street: _____

_____

City: _____

State, Zip: _____

Duty Phones:

Commercial: _____

DSN: _____

Fax:

Duty Status: ☐Active ☐Active Guard Reserves ☐National Guard ☐Reserves ☐Other_____

Special Duty Status: (Check with your Unit Surgeon before submitting)

☐Airborne ☐Ranger ☐HALO ☐Aviation (please confer with you flight surgeon about additional paperwork)

☐Special Operations ☐SCUBA ☐Air Assault ☐Other:_____

MANDATORY QUESTIONS:

Your initials indicate you completely understand the statement or question. If you don't understand, ask your local eye care clinic for help.

1. I understand that PRK/LASIK may not correct all my myopia, hyperopia, or astigmatism and that I may still need to wear glasses or contact lenses after PRK for best correction of my vision — Initials:
2. I understand there is a chance I cannot be fitted with contact lenses after PRK/LASIK. — Initials:
3. I understand that if PRK/ LASIK is not successful there is a possibility that I may lose my special duty status and/or may never meet vision standards for application into special duty programs. — Initials:
4. I understand there is a small risk of not meeting relevant vision standards after PRK/LASIK. As a result, I may be disqualified permanently from certain career fields or even continued military service. — Initials:
5. I understand that during my evaluation at a GPRMC laser center, I may be disqualified as a PRK/LASIK candidate and will not be treated. The final decision will be made by my surgeon. — Initials:
6. If I am disqualified as a PRK/LASIK candidate after arriving at a GPRMC laser center, I mat not be eligible for reimbursement of expenses incurred for travel to/from the DoD laser center, including, but not limited to, travel, meals, and lodging. (This does not apply if I am unit-funded.) — Initials:
7. Any history of eye injury or other eye history that might impact PRK/LASIK? ☐Yes ☐No

Explain if answered "yes":_____ — Initials:

Signature of Applicant:	Print Clearly: (last name, first name, mi)	Date Signed:

Commander's Authorization
Warfighter Refractive Eye Surgery Program (WRESP)

1. I hereby give my endorsement/permission for the following Soldier to be evaluated and considered for enrollment in the WRESP and for their PRK/LASIK eye surgery if eligible.

Name: _____ **Rank:** _____
Last, First, MI

SSN: _____ **ETS Date:** _____ **MOS:** _____ **Duty Title:** _____

Assigned Unit: _____

Contact Address: _____

Contact Phone: (day) _____ **(evening)** _____

E-mail address: _____

Likely to do travel for the following reasons in the next 4 months? (please circle) PCS TDY Deploy School **Projected date (if known):** _____

2. I certify that the following are true and will inform local MTF eye clinic if Soldiers circumstances change:
   a. Soldier has 18 months remaining on Active Duty
   b. Soldier has no adverse personnel actions pending
   c. Soldier will remain CONUS for at least 60-90 days

3. I realize that after surgery, the Soldier will have at least 4 days of convalescent leave. In addition, I understand that the SM will have the following profile for a minimum of 30 days:
   a. No field duty or driving military vehicles
   b. No organized PT – may do modified individual PT
   c. No swimming, protective mask use, or use of camouflage face paint
   d. Needs to wear sunglasses at all times

4. I further realize that participation in this program requires a considerable investment of time resulting in absences from duty and will ensure that the Soldier will keep all appointments. Minimum requirements are as follows:
   a. Initial evaluation (local medical treatment facility (MTF)) – up to half a day
   b. Surgery – one week off work, up to two weeks, especially if Soldier has to travel for surgery
   c. Postoperative evaluations (local MTF) – normally scheduled at a minimum of 1, 5, 30, and 90 days after surgery. Appointments can follow until 1 year post op.

5. Please circle one of the following according to which category applies to this individual:
   a. Priority 1 – Deploying/ Combat Arms MOS
   b. Priority 2 – Attached to Combat Arms unit
   c. Priority 3 – Space Available

6. I understand that if Soldier needs to travel to another facility to receive refractive surgery, all TDY costs will be incurred by the Unit or the Soldier receiving the elective refractive eye surgery.

7. This authorization is good for 90 days from the date it is signed by the Battalion Commander. If surgery is scheduled more than 90 days from the date it is signed, re-authorization will need to be accomplished.

Company Commanders Signature	Battalion Commanders Signature
Company Commanders Name and Rank	Battalion Commanders Name and Rank
Date / Phone	Date / Phone
Company Commanders Email Address	Battalion Commanders Email Address

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General.

REPORT TITLE **PATIENT HISTORY QUESTIONNAIRE** | **DATE** *(YYYYMMDD)*

Last Name, First Name, MI				Rank/Grade	MOS	Occupation/Duty Title
SSN	Date of Birth	Age	Home Phone	Work Phone	Address	
Emergency Contact *(other than spouse)*			Phone	Relationship	Your Primary E-mail	

List some of your hobbies or activities that require visual needs:
(example: biking, crafts, computers, sports, etc.)

1. _____
2. _____
3. _____
4.

What do you hope to achieve from having laser eye surgery?
(example "to be able to wake up in the morning and see the clock")

1. _____
2. _____
3. _____
4.

REFRACTIVE HISTORY

How many years have you worn glasses?

Ever worn bifocals? ☐Yes ☐No

How old is your current glasses prescription?

How long have you worn contact lenses?

Last worn? *(DD MMM YYYY)*

Contact lens type: ☐ Soft ☐Rigid

Brand worn:

Have you ever had difficulty with glasses or contact lens wear?
(If YES, please explain further)

OCULAR HISTORY

Do you or have you ever had the following eye problems?

Amblyopia / lazy eye	☐Yes	☐No
Cataracts	☐Yes	☐No
Conjuctivitis, recurrent	☐Yes	☐No
Corneal ulcer	☐Yes	☐No
Double Vision	☐Yes	☐No
Dry eyes	☐Yes	☐No
Glaucoma	☐Yes	☐No
High eye pressure	☐Yes	☐No
Herpes simplex / Zoster	☐Yes	☐No
Keratoconus	☐Yes	☐No
Retinal problems	☐Yes	☐No
Trauma	☐Yes	☐No

Other (specify)

ALLERGIES

Do you have any allergies to medications? ☐Yes ☐No
(Please list medication and reaction)

MEDICATIONS

Are you taking or have you taken any of the following?

Accutane (isotretinoin)	☐Yes	☐No
Birth control pill	☐Yes	☐No
Cordarone (amiodarone)	☐Yes	☐No
Immunosuppressants	☐Yes	☐No
Imitrex (sumatriptan)	☐Yes	☐No
Steroid medication	☐Yes	☐No

List other medications that you are currently taking:

MEDICAL HISTORY

Do you or have you ever had the following?

Arthritis	☐Yes	☐No
Breathing Problems	☐Yes	☐No
Diabetes	☐Yes	☐No
Heart Problems	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Migraine Headaches	☐Yes	☐No
Pacemaker	☐Yes	☐No
Immunosuppression/HIV	☐Yes	☐No

Other Medical Problems (specify)

OCULAR SURGERY

Have you ever had surgery or laser treatments on your eyes?
☐No ☐Yes (specify)

Name of Eye Care Provider | **Phone**

PATIENT SIGNATURE: _____

TO BE COMPLETED BY THE WARFIGHTER LASER CENTER STAFF:

SURGERY TECHNICIAN COMMENTS

Technician Signature: _____

SURGERY PHYSICIAN COMMENTS

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	*DATE (YYYYMMDD)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐TREATMENT

☐FLOW CHART
☐ OTHER *(Specify)*

WARFIGHTER LASER SURGERY CENTER
MANAGED CARE AGREEMENT

PATIENT NAME _____ SSN _____

SERVICE/STATUS _____ FORT/LOCATION _____

RANK _____ PHONE _____

PATIENT AGREEMENT

I REQUEST TO BE RETURNED TO DR. _____FOR POSTOPERATIVE CARE FOLLOWING REFRACTIVE SURGERY AT THE WARFIGHTER LASER SURGERY CENTER. I KNOW THAT THE STAFF OF THE WARFIGHTER LASER SURGERY CENTER WILL BE AVAILABLE FOR ADDITIONAL CONSULTATION AS NEEDED.

PATIENT SIGNATURE _____ DATE _____

REFERRING DOCTOR'S AGREEMENT

I AM QUALIFIED AND CAPABLE TO MANAGE THIS PATIENT AND I ACCEPT RESPONSIBILITY FOR HIS/HER POSTOPERATIVE CARE. I WILL SUBMIT ALL POSTOPERATIVE FOLLOW UP EXAMS TO THE TREATING WARFIGHTER LASER SURGERY CENTER. I ALSO AGREE TO REFER THIS PATIENT PROMPTLY IF A CONDITION PRESENTS POSTOPERTIVELY THAT WILL REQUIRE FURTHER TREATMENT BY THE WARFIGHTER LASER SURGERY CENTER.

POSTOPERATIVE APPOINTMENT SCHEDULE 1 WEEK/1,2,3,4,6,AND 12 MONTHS

REFERRING OPTOMETRIST SIGNATURE _____ DATE _____

PRINT OR STAMP NAME, RANK _____ DUTY PHONE _____

FORT/LOCATION _____ DUTY FAX _____